Health Benefit Exchange and the Commercial Market: Public Meeting
Nevada Division of Health Care Financing and Policy (DHCFP)
Cashman Convention Center, 850 N. Las Vegas Boulevard, Las Vegas, Nevada
Wednesday, March 30, 2011 1:00 PM – 3:00 PM
Notes from Meeting: Q&A

I. The Exchange and the Commercial Market Presentation

- Speakers:
  - Gloria Macdonald, CPA – Project Manager for Health Care Reform, Division of Health Care Financing and Policy (DHCFP)
  - Bob Carey – Senior Advisor, Public Consulting Group (PCG)
  - Brett Barratt – Nevada Insurance Commissioner

II. Questions/Comments

- **Teresa Etcheberry, Clark County Social Services**
  - Question: Currently the State of Nevada mandates all counties to provide indigent medical care. Under the new plan in 2014, what will happen with that state law and will the county still be expected to pick up whoever falls in that gap?
  - Answer: The county indigent program is an example of a program that needs to be modified because the population that it is targeted to serve is going to change. Counties will need to figure out how the program can be modified to fill in the gap of people who may not be able to afford coverage or who may choose not to enroll in Medicaid. How this will occur is a to-be-determined change. The State is in the process of putting together an overview of all public programs to better understand which programs will need to be modified/consolidated, etc.
  - Question: When someone does not sign up for insurance and ends up in the emergency room, who will pay the bill?
  - Answer: There will surely be people who will continue to be uninsured and not covered. Those folks will still go to the hospital for care, and figuring out who pays the bill and how they are going to be supported will be an important policy question.

- **Larry Harrison, Harrison Insurance Agency**
  - Question: If the essential health benefits do not include all the mandates that Nevada currently has, is it conceivable that Nevada will cut back on some of its mandates? Otherwise, it sounds like the State is going to have to pay for those mandates, and we have always said that Nevada has too many mandates anyways.
  - Answer: As far as mandates go, Nevada is number four in the nation in terms of the number of mandates. The legislature needs to take a close look at the current list of mandates in Nevada and reconsider some of those mandates if they are not included in the essential benefits package. We need to balance the state's budget needs with the desire to provide those care items to Nevadans. We will not know how the essential health benefits package will compare to Nevada until they are released, but the feeling is that they will be more inclusive rather than less inclusive.

- **Bobbette Bond, Culinary Health Fund**
  - Question: If the State has to pay for the mandates that exceed the essential benefits, is it only for the plans sold through the Exchange, or does that apply to all plans in the State?

- Answer: That applies only to those plans sold through the Exchange. This also brings up a fairness issue. If in 2014 the State decides that it is going to pay for those mandates that fall outside of the essential health benefits, it will be more expensive for people to purchase coverage outside of the Exchange, because the State will not subsidize those extra mandates in plans sold outside of the Exchange. In addition to this cost issue, policymakers need to grapple with the potential for risk selection. If you have different items that are covered and paid for outside the Exchange versus inside the Exchange, it is not a level playing field.

- **Jerry Austin, Insurance Solutions**
  - Question: Are all carriers going to provide plans through the Exchange?
  - Answer: The current thinking is that the State is not going to require carriers to participate. It is something that the State could do, but the free market approach is to try and entice carriers to want to be in the Exchange. The Exchange, through the subsidies for individuals, may double or triple the size of the individual market. Carriers are competitive, and if the Exchange is structured properly, you would expect that they will want to be listed on the Exchange.
  - Comment: What about the small group market?
  - Answer: The small group market is a different case than the individual market, and a lot of policy and important decisions need to be made about how the Exchange is going to structure the small market offering. The Nevada Exchange will not be the exclusive distribution channel for either individuals or small groups; they will still be able to purchase small group coverage through their current distribution channels.
  - Question: If carriers decide that they really do not want to alter their plans to fit the models specified within the Exchange, what will the Exchange have to do if no carriers participate?
  - Answer: We are optimistic that carriers will want to participate in the Exchange and that we will be able to build an Exchange and involve the carriers in the process to make it attractive for them to be there.

- **David Dahan, Orgill/Singer & Associates**
  - Question: We are assuming that the prices within the Exchange are going to be competitive with the free market, but what if they are not? Are the prices for the products within the Exchange going to be artificially set and subsidized by someone else?
  - Answer: The Exchange is not a separate pool. Each carrier may offer individual products in the commercial market and through the Exchange, but they will have a single risk pool comprised of all individuals that purchase individual health coverage in the individual market. Some of those people may come through the Exchange; some of those people may come from outside the Exchange. They will all be part of one risk pool, and the premiums will be the same inside and outside of the Exchange.
  - Question: You mentioned earlier the fairness issue of having some essential benefit mandates inside the Exchange and not necessarily in the private sector. If we are talking about carriers only having one risk pool, and the private sector has to have a product that is essentially more expensive to deliver than the Exchange, who assesses the fairness of what's happening in the marketplace?

- Answer: The benefits inside and outside the Exchange need to be the same. You shouldn't require certain things outside the Exchange and you shouldn't require different things inside.

- **Frank Clemensen, Clemensen Insurance Services**
  - Question: To clarify, you are saying that plans inside and outside of the Exchange are going to be pretty much the same, with the same risk pool and possibly the same benefit structure with essential benefits and so forth, yet plans within the Exchange will be at lower prices?
  - Answer: Not exactly – the total premium will be the same for an individual whether that individual purchased the plan inside or outside of the Exchange. The difference could be if that individual was eligible for a subsidy, he can only get that subsidy if he purchases through the Exchange. So, the net premium would be different, but the total amount that goes to the carrier will consist of the individual's share of the premium and the subsidy from the Federal government.

- **Steve Spinello, R & R Partners for Nevada Resort Association**
  - Question: What role do those that provide self insurance have in the Exchange?
  - Answer: In terms of the ability of the self-funded plans to just come through the Exchange, I don't see how it could work. It's a fully insured product.

- **David Dahan, Orgill/Singer & Associates**
  - Question: My understanding is that the navigators are going to be the ones able to sell the Exchange, along possibly with brokers, is this correct?
  - Answer: The role of the navigators is yet to be determined, but navigators will have more of an outreach and education role as opposed to enrolling people in coverage. The law prohibits navigators from being compensated based on enrolling people in coverage. Navigators will be non-governmental organizations. It could be a county-based organization, a faith-based organization, chambers of commerce, or trade associations, etc. who are provided grants by the Exchange to spread the word. There are new programs available, including Medicaid expansion and subsidies through the Exchange, to help people enroll. It is not envisioned that the navigator will replace the broker. There is going to be a clear delineation between the two.
  - Question: There are some comments that a navigator may have to be licensed. Who is going to be licensing them, is that the Insurance Division?
  - Answer: We are still waiting for the Secretary of Health and Human Services to issue more specific regulations regarding the criteria for being a navigator, because the current provision is very general. I do not envision that the Secretary will say that the role of the navigator equals broker, as being a navigator means that you cannot directly or indirectly be compensated from a carrier for brokering coverage. One potential resource for information until the secretary establishes these regulations is the National Association of Insurance Commissioners. Just last week, they finalized a white paper on the role of the navigators.

- **Len Berend, Barend Agency**
  - Comment: I am concerned about the role of navigators. While I understand that this law has not been finalized, it seems to me that to maintain a license as a broker, I must pay certain fees, as well as take 30 hours of continuing education every three years. If you

go further into other areas in the insurance world, you have other licensing requirements. Even though navigators are not compensated with commission, they are on salary. It seems that they should include brokers in the Exchange and substitute the word "navigator" for "broker" to allow us (brokers) to continue to do the job that we do right now.

- Answer: It is up to the Federal law to define the role of the brokers and navigators. With regard to the licensure of navigators, this is a very valid concern. We do not have navigators today, so we do not license navigators. We will have them in the future. We need to decide if they will be licensed and who will enforce what they do. There are questions that still need to be addressed, and we welcome your input.

- **Melissa Amaon, Kia Insurance**
  - Comment: It's important to remember that there is a huge fiscal impact on the State making sure that people who come to a navigator get directed to the proper channel – making sure that people do not go into the wrong program.
  - Answer: Eligibility will be determined through the Exchange, not through the navigators.
  - Question: Will navigators be directing them in some manner?
  - Answer: Not every person that is going to come to the Exchange will go through a navigator. There will be many different ways for people to come to the Exchange. You can go directly to a website; you can phone into a call center; you can walk in; or, you can mail in. There will be a single form that people will fill out to determine whether they are eligible for the Exchange, Medicaid, CHIP, or not eligible for anything. Everyone that seeks coverage through the Exchange or through Medicaid will be run through what we envision as a single streamlined application process.
  - Question: How often would they need to re-qualify?
  - Answer: Medicaid rules are constant. You have to tell them any time there is a change in status. The Exchange will likely be on an annual basis, but remember there will also be a point of reconciliation. If an individual comes into the Exchange and is deemed eligible for a subsidy, but then their tax return reveals that they were making more than what they said they were making, they will need to pay the difference in what the premium subsidy was, versus what they were in fact really eligible for.

- **Bobbette Bond, Culinary Health Fund**
  - Question: To clarify, this eligibility form that individuals will fill out is going to determine whether someone qualifies for the Exchange, Medicaid, etc., but the IRS ultimately evaluates whether they should have the subsidies?
  - Answer: Think of it as a single eligibility engine. Whether you are applying for Medicaid or the Exchange, the process will connect with the Federal government's database, the IRS, Homeland Security, and Social Security, all in real-time. An applicant fills out their family status, income, etc. and this information will link to the IRS's database that confirms how much someone earns. The subsidy is in essence an advanced tax credit, so instead of paying out-of-pocket for the whole premium and then applying for a tax credit when you file your taxes, you are being given the credit up front.
  - Question: The individual, not the carrier, repays the Federal government for the subsidy that they received?
  - Answer: Yes, the plan is held harmless. The individual is held accountable, because the individual was in essence getting more money than what they qualify for from the federal government to pay their claims.

- **David Dahan, Orgill/Singer & Associates**
  - Comment: I want to comment on the difficulty of this conversation that we are having with insurance experts. Imagine this discussion with a person who has never purchased insurance.
  - Answer: The state is responsible for determining the eligibility and the level of subsidies for individuals. People need to be advised, however, of the fact that if they have a change in status, or if they get laid off or hired at a different salary, their eligibility could change. This is how it works today in the Medicaid program.
  - Question: Will the broker be part of that discussion?
  - Answer: The broker will not be part of that discussion – the broker needs to advise the individual that if there is a change in status or if the individual gets hired, their subsidy could change. You make a good point about the people who will be eligible for the subsidy. Looking at the breakdown of data, as your education level goes up, the likelihood that you have insurance also goes up. We are not talking about a college educated group of people who will likely be the vast majority of people who are eligible.

- **Melissa Amaon, Kia Insurance**
  - Question: Revisiting the subsidy qualification discussion – employers will be penalized if they have an employee go to the Exchange and apply for a subsidy because they have not met the 90 percent rule of providing coverage that doesn't exceed 90 percent of the family's income tax. What mechanism will employers have for accessing that information of qualification prior to someone going and applying for a subsidy? In other words, if I'm employing somebody, I want to make sure that I'm meeting that criteria so that I do not get penalized, not only on that person, but on my entire employee population.
  - Answer: The law that you are talking about applies to employers with over 50 employees – that's one thing to keep in mind. The other thing to keep in mind is that the Exchange will have the responsibility of notifying the employer that their employee has applied for coverage. The employer has to provide information on that individual. If they indicate that the insurance offered by the employer exceeds nine percent, then the individual is eligible for a premium subsidy and because of that, the employer could be liable for a penalty.

- **Brian McEvilly, McEvilly Group**
  - Question: Massachusetts has been looked at as somewhat of the precursor for federal healthcare reform. Is there an Exchange set up in Massachusetts, and if so, how is it functioning?
  - Answer: They have what's called the Massachusetts Connector. It is materially different from the Exchanges that will be required under Federal law. The biggest difference is the health plans. The health plans offered for subsidized coverage through the Connector are primarily Medicaid MCO plans; they are not commercially available plans. It is also an entirely separate risk pool, so if you are eligible for subsidized coverage through the Massachusetts Connector, you are not part of the individual pool. The Board decides the benefits package – you really don't have a choice. The choice is between the different MCO plans. They do offer non-subsidized coverage, which is individual and small group market policies that are sold inside the Connector and outside the connector.

There's a material difference between the way that the Connector in Massachusetts sells subsidized plans and the way that the Exchange will be structured. The biggest difference is a single risk pool, and that the subsidized coverage will be commercial, not Medicaid.

- Question: Is there the same discussion going on in Massachusetts regarding the broker versus the navigator roles?
- Answer: It's a huge discussion there, as well, but there are a few differences. In Massachusetts, prior to reform, brokers did not operate in the individual market. They were not compensated, and they did not sell individual insurance, so it wasn't as if the introduction of the Connector somehow affected an existing relationship that individuals had with a broker to get insurance.
  In the small group market, however, they do compensate brokers. Brokers do not get commission from the Connector.
  The state changed the composition of the Connector board to include a broker on it because it has been such a major continuous discussion. That will take effect in July of 2011.

- **Tim DeRosa, Business Benefits, Inc.**
  - Question: Isn't it more accurate to say that while brokers and agents can't be compensated under their current commission schedules, they could, in fact, be navigators on the Exchange?
  - Answer: Sure. There's no preclusion of brokers or navigators. There's preclusion under compensation.
  - Question: Do you imagine that the subsidy issue will create an adverse selection problem, and do you have a solution to that?
  - Answer: The biggest challenge will be outreach and informing people that they are eligible for coverage. The worst thing to do would be to set up enrollment centers in hospital emergency rooms. The key is going out and getting young folks who are currently uninsured into the risk pool because that is the only way to be able to have a broad enough risk pool to sustain the Exchange. If it is only people who are sick and in need of coverage who enroll, the Exchange will not be able to sustain itself.
  - Question: It is possible then, that we will still have a significant number of uninsured coming into the hospitals with emergent situations that would not have access to coverage, even after 2014?
  - Answer: A big concern of the carriers is someone calling in to get insurance in the ambulance on the way to the hospital, because there is no pre-existing condition exclusion. This is why we will need to establish open enrollment periods. Those open enrollment periods would, however, be subject to certain exceptions.
  - Question: What penalty is imposed on the individual that comes in without coverage?
  - Answer: It is a sliding scale based on income, and it is up to two percent of income.
  - Comment: This means that it is still cheaper than actually paying for coverage. The population that we are talking about is the population that do not particularly care about being covered, otherwise they would be covered now.
  - Answer: They may not be able to afford coverage now. If someone makes $20,000 a year, it is tough to afford a $400 a month insurance policy.

- **Marilyn Wills, Office of the Governor Consumer Health Assistance**
  - Comment: The model that they have described for the people who will do some of the enrollment – is modelled after the CHIP model that has been available for years. Those people are highly trained. CMS put together a very sophisticated training for the CHIP volunteers and the CHIP staff. I think the idea is to highly train those people to guide them and help them find the most appropriate kind of coverage.

- **Rod Santa Cruz, Orgill/Singer & Associates**
  - Question: What about illegal immigrants? If the idea of the Exchange and health reform is to reduce cost of care, which I believe it truly is, what do we do in the situation where someone gives a false social security number?
  - Answer: Applicants need to provide information that would determine that they are a U.S. citizen – a social security number, a date of birth, etc, so we will be able to determine if it is a false social security number.
  - Question: Then there will still be uninsured individuals, so how does Nevada pay for these people who go to the emergency room to get care?
  - Answer: This situation exists today where people who are uninsured go to the emergency room, and there will continue to be people that fall between the cracks or otherwise are not eligible for programs.
  - Question: Can you clarify what you were saying earlier with regards to if a carrier has a lower MLR, then somehow they do not have to pay into a certain pool, is that correct?
  - Answer: I was describing the risk corridors program. Close to the end of the year, the claims that a carrier pays out on the individual or small group market will be divided by the premiums that they collected. If the numerator is greater than the denominator, that is, if they paid out more in claims than they received in premiums, minus their allowable admin, some portion of that amount will be shared by the risk corridors program. The MLR is a separate issue. It is really paid-out claims versus premiums that they received. Those carriers that received more in premiums than they actually paid out in claims, minus within some range, have to pay into the program.
  - Comment: This is then a reserve for future use and perhaps they may need it the following year. For carriers that did not pay into the risk corridor program, it is because they ran a better business.
  - Answer: Or it could be that they worked it out so that their targeted medical payments equalled what the targeted premiums were.

III. Conclusion

- Thank you all for coming. The next meeting will be in Elko on April 12 at the Hilton Garden Inn. It will be another general overview of the Exchange.